ADDITIONAL PATIENT INFORMATION

Name		DOB	

ETHNICITY AND RACE IDENTIFICATION

RACE	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other: _____ ☐ I do not wish to share / respond	ETHNICITY	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I do not wish to share / respond
		PREFERRED LANGUAGE	

PROVIDERS WHO CARE FOR YOU (PRIMARY CARE MD / NURSE PRACTITIONER / SPECIALISTS)

	NAME OF SPECIALIST		**NAME OF SPECIALIST**
PRIMARY CARE MD	*Andrew M Romanowsky, MD*	**PHYSICIAN ASST**	*Eikatarine T Berube, PA-C* *Danielle J McGinty, PA-C* *Heather L Thyne, PA-C*
ALLERGY		OPHTHALMOLOGY	
CARDIOLOGY		ORTHOPEDICS	
DERMATOLOGY		PAIN MEDICINE	
ENDOCRNOLOGY		PODIATRY	
EAR, NOSE & THROAT		PSYCHIATRY	
GASTROENTEROLOGY		PULMONARY / SLEEP MEDICINE	
NEPHROLOGY / KIDNEY		RHEUMATOLOGY	
NEUROLOGY		UROLOGY	
OB/GYN		VASCULAR	
ONCOLOGY		OTHER	

CHIROPRACTORS, ACUPUNCTURISTS, HERBALISTS AND THERAPISTS

CHIROPRACTOR	
ACUPUNCTURIST	
HERBALISTS	
THERAPIST	
SOCIAL WORKER	

OTHER SUPPLIERS / DME SUPPLIERS FOR OXYGEN, C-PAP, DIABETIC SUPPLIES, ETC.

C-PAP	
DIABETIC SUPPLIES	
OXYGEN	

Today's Date: _____ Patient's Initials: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

DOB: _____

Over the last 2 weeks, how often have you been bothered by the following problems? (*circle a number to indicate your answer.*)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

If you responded 'Not at all' to <u>both</u> questions 1 & 2, you do not need to complete the next section of form.

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3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or over eating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)

TOTAL: _____

10. If you checked off any *problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very Difficult _____ Extremely difficult _____

Patient Name:_____ DOB: _____

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Interpretation

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety